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ABSTRACT

Parent training goals, models, and predictors of effectiveness are examined with examples from three parent training models: (1) a combination of group sessions and intensive in-home consultation visits to prepare families receiving their child home again after residential treatment; (2) intensive in-home training intended to prevent residential placement by early intervention with preschool aged developmentally disabled children; (3) short term group training designed to disseminate basic teaching skills to a large number of parents of developmentally disabled children. Training goals may vary depending upon conceptual model, agency mission and resources, and population served. Program model components also may vary on format, location, composition, staffing, curriculum, and place in service delivery. There is presently little research evidence from which to select an appropriate model for a given training goal. Criteria for determining whether a program works include enrollment, completion, participation, proficiency, maintenance, and placement statistics. Among considerations in determining for whom a program works are demographic variables, parents' expectations, prior related experience/skills, child characteristics, and family characteristics. (DB)

American Association on Mental Deficiency: 1986

Symposium: Parent training: Models and predictors of outcome.

Introduction to the symposium.

Bruce L. Baker

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This symposium is about training programs for parents of young children with developmental disabilities. Parent training programs have proliferated over the past two decades; hundreds of programs have been described in the professional literature and there are hundreds, perhaps thousands, more about which we know very little.

Proponents of this model of service delivery argue its advantages. At some point most parents want to learn better ways to live with their handicapped children; many enroll in training programs and demonstrably gain knowledge and skills. Children learn more and faster when their parents are enlisted as teachers and the home becomes a place to learn. Teachers can work with parents to increase the likelihood that gains at school are generalized to the home. And there are the possible intangible benefits. Parents who become more able to cope with the child's handicaps may become, for example, more confident and optimistic; this seems reasonable, although such attitudinal changes are difficult to document.

Critics argue the disadvantages. Training programs, they note sometimes make many demands on parents, perhaps in some cases actually increasing the perceived burden of raising a handicapped child (Turnbull & Turnbull, 1982). Moreover, many familiy needs are not met by parent training programs, and some critics object in principle to the problem oriented view of raising a mentally retarded child inherent in training programs. Failures are noted: all parents do not succeed in becoming

better teachers of their child and even fewer succeed in implementing what they have learned over the long haul.

Each of these positions -- pro and con -- has some merit. But the argument is reminiscent of the age old question in clinical psychology: Does psychotherapy work? After years of study and debate, it became apparent that this was the wrong question. A more sensible question, although one more difficulty to study, is multi-variate: "Which psychotherapeutic methods, implemented by what types of therapists, work according to what criteria for what kinds of people with which problems?" Similarly in parent training, every program will likely have some benefits for some families and some limitations as well. We need to appreciate the wide array of parent training approaches and ask about the specific benefits and drawbacks of each for a given family.

Today we examine three distinct models of parent training. The first combines group sessions and intensive in-home consultation visits to prepare families to accept their autistic child back home from residential treatment. The second is an intensive in-home training program that seeks to prevent placement by early intervention with pre-school aged developmentally disabled children. The third is a short-term group program that seeks to disseminate basic teaching skills to a large number of parents of children with developmental disabilities. In the final paper, I will consider parent training goals, models, and predictors, illustrating with examples from these three programs. We will leave 30 minutes for a discussion. We want to ask for your participation, in sharing with all of us two things: (1) parent training program models that you are familiar with, and (2) your thoughts about factors that relate to families doing well or poorly in those models.

Parent Training: Goals, models, and predictors

Bruce L. Baker

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I want to share some considerations that are raised in developing a parent training program, illustrating from the three innovative programs we have just heard about. We must ask ourselves three basic questions: What are our goals? What model will we implement to meet those goals? and What families will be best served by that model?

Goals.

First, what are our goals -- and what are not our goals? Families with a handicapped child have many needs, and the relative balance of these needs changes throughout the family life cycle. No one program can meet all of these needs, so an important initial task is to delimit which family needs the program will target as goals and which will not be targeted. Some program goals are dictated by a conceptual model, others by the particular agency's mission and resources, and still others by the population served.

One conceptual model, that of behavioral parent training, is illustrated by the three programs we have just heard about. They all have a primary child focus -- they seek to build children's skill repertoires and reduce behavior problems. Since this is accomplished by enhancing parents observation and teaching abilities, these programs focus on parents and the parent-child relationship. But the end goals are for the child: for him or her to develop better and live in the home as much as possible. Because these outcomes are likely best realized in families that are well adjusted, accepting, and competent, secondary goals are to increase the psychological well being of the parents and the family system. The pathway to this is seen to be primarily through

promoting more successful coping with the child. Programs with a different conceptual model will establish other goals, such as decreasing psychological problems of individual parents, couples, or families, providing social or spiritual support or increasing parents' knowledge about retardation, advocacy, and services.

We see some differentiation in goals among the three programs that are dictated by the agencies' missions. The goal of the May Institute's residential program is to return almost every child to the natural home. This agency goal dictates that the program for parents must work with a given population and have a very high success rate, for failure in parent training can make three or four years of successful residential programming fruitless. On the other hand, The Project for Developmental Disabilities does not have its own population. We work through Regional Centers that have caseloads in the thousands and where the mandate is to provide some benefit to a large number of families.

Goals also will vary with different handicapping conditions. The May Institute programs serve primarily autistic children. To successfully treat these children requires a carefully and highly programmed environment, and to do this successfully at home requires parents to have very good teaching skills and to impose an organization on their life and home that does not usually come naturally. The Project for Developmental Disabilities primarily serves families with moderately or severely retarded children who are already in school programs. Parents can enhance these children's development with less major alterations of natural practices. The media based program reported on today aims to increase parent knowledge and expertise in one limited albeit important area -- self help skill teaching. While successful

teaching requires some commitment and structure, it requires much less of both than to attain success with autistic children.

Models

With a clear conception of goals, we can proceed to choosing a training model or models. An immediate difficulty arises when one's agency does not have the resources to implement a model that fits with its goals. For example, many of you may share my enthusiasm for the May Institute's very successful prevention program, while at the same time recognizing that your agency does not have the staffing available to carry this out. And yet with autistic children, a staff-intensive program may be needed to produce any progress. Ivar Lovaas at UCLA has found some extraordinary results in his Young Autism Project. When autistic children entered treatment by age 3 years and were treated at home 40 hours a week for a year or more, about half subsequently were successfully placed into regular first grades. Lovaas' control group showed minimal progress; yet they actually received 10 hours a week of in-home training, more than almost any other program that we know of.

As we decide among different models to implement, we find a bewildering array of factors on which parent training program differ. To name but a few, parent training programs vary on format (e.g. individual consultation vs group); location (e.g. agency-based vs home); composition (e.g. homogeneous groupings vs heterogeneous ones); duration (e.g. time limited with few sessions vs open ended); staffing (e.g. professional leader, vs non-professional or series of speakers); curriculum (e.g. precise plan vs more flexible) and place in service delivery (e.g. primary intervention for family and child vs an ancillary service). There are certainly more.

Despite the demonstrated successes of parent training generally, we

find very few specific findings in the literature that help us to decide among these components of a training program. Consider format, for example, since this has been most studied. Practically all studies that have compared individual and group training have found that outcomes have not differed, whether measured in parent or child gains (Brightman, Baker, Clark & Ambrose, 1982; Christensen, Johnson, Phillips, & Glasgow, 1980; Salzinger, Feldman & Portnoy, 1970). These results seem to argue convincingly for the group model, because it is less costly to conduct.

Even here, however, a closer look suggests caution. These studies, typical of the parent training literature, were mainly conducted by university-based researchers who did not have an ongoing service commitment to a target group of families. It fit their purpose and resources to conduct time limited programs with relatively narrow goals. We do not know, then, how individual and group formats would compare for longer programs. Moreover, we do not know how they impact on other unmeasured areas of family attitudes and functioning. We do not know if they impact differentially on different children (e.g. autistic, retarded). And we do not know yet whether the two formats could be combined into an even more successful program than either alone. And formats are the area most studied!

We are then, all the more compelled to examine our goals carefully and to use our best clinical judgement about which program components are most likely to meet the goals we have set. It would be helpful in choosing among models and components of models, to have available to us descriptions of more program models, including those that have not appeared in the literature. In an effort to obtain more complete

program information, the UCLA project is embarking on a nationwide survey of parent training programs. We will begin with a questionnaire and then follow up selected programs with interviews. And we encourage any of you affiliated with a program or knowing about a program to give us your name and address on the pink forms, so that we can include you.

Predictors:

A third important question is: Which families are likely to benefit from this program? We might further ask, which of these parents would have done well or poorly in any program model -- and which might have had different outcome with a different approach. Obviously this is a question to consider as one selects goals and defines a model. However, it is also a primary outcome question to ask.

Insert Table: Did the Program Work?

Here is a list of 10 possible outcome criteria, each of which might be meant when one asks "Did the program work?" (List criteria). If a large number of families do not benefit, by whatever criteria are deemed important, than it makes sense to examine and change the program. If a small number do not benefit, it makes most sense to examine these families individual characteristics.

When we ask the predictor question -- what characterizes high or low outcome families -- within any model we are likely to get different answers depending upon what outcome criteria we are interested in. Let me illustrate from our research on predictors of outcome in a 10 session behavioral group training program. I will draw from our studies of predictors of outcome in two samples, with 103, and 44 families who had children aged 3 to 13 with moderate or severe mental retardation (Clark & Baker, 1983; Baker & Clark, in press).

For simplicity, let us simply consider two of these criteria: Completion and Proficiency. The next slide illustrates the types of predictors that we have examined; the list is by no means exhausive.

Insert Table: Who Did the Program Work For?

It seems logical that a number of these factors would predict whether a family completes the program or not. To select just several examples, we might expect lower completion rates with lower socioeconomic status families, or those who have to drive far to the meeting place, or those who enter with less commitment to teaching, or those with poor marital adjustment.

In fact, only one variable on this list has consistently predicted which families will complete or dropout. That variable is marital status. Single parents had a lower completion rate than married parents, even when only one member of a married couple attended. This finding replicated dramatically in the media study that Kathleen Kashima has just reported. In this brief four session program, 7 (of 41) families dropped out. Of intact families, 94% completed the program; of single parent families, only 38% completed. It is clear that this type of group training is not an optimal model for single parent families.

Now consider the criterion of post-training proficiency, as measured by knowledge acquired, demonstrated skill in a teaching session with the child, and the group leader's evaluation. The most consistent predictor here is socioeconomic status and its correlates, education and family income. Lower socioeconomic status families are less likely to attain proficiency in this time-limited program. There is evidence that in programs that do not limit the number of sessions and/or those that

involve direct supervised teaching with the child, lower socioeconomic status parents fare better. (Baker, Prieto-Bayard, and McCurry, 1984; Rogers et al., 1981).

I offer these selected findings to make this point: we must decide which outcome criteria are important to us in our programs and we must test our assumptions about which parents will fare well or poorly.

You may be feeling, in seeing my list of ten possible outcome criteria and this long list of possible predictors, that such a comprehensive assessment is fine for researchers but impractical for a program that has the primary goal of service provision. That is indeed true. One criterion of outcome is most important and quite practical and I have saved it to mention last. That is consumer satisfaction.

Parents evaluation of the program, along with completion rates, can be taken readily by any program. Participant feedback is essential for refining the program. It can be taken anonymously, although there is more to be learned from finding out which particular families gave higher and lower assessments of the experience. In this way we can see which families feel best served by this particulkar program and which families might need an alternative approach. Such a measure has high utility. Ours can be administered in 10 minutes at most and is easy to score. Most importantly, this type of measure leaves parents feeling that their opinions have been valued. Kathleen has given results of the consumer satisfaction measure we used in our most recent study: media based parent training. We have copies of this measure if any of you would like one; feel free to adapt it to your own use.

In conclusion: First, it is important to be clear with ourselves and with our clients what the goals of our parent training programs are. And are not. Second, we should choose from the array of possible

training models one or several that seem most likely to meet these goals. Third, we should be aware of our successes and failures, at the very least tallying dropouts and obtaining from parents who complete the program a measure of consumer satisfaction.

At this time, I would like to open the floor for discussion. We are particularly interested in hearing, of course briefly, about your program and what you think may predict outcome.

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DID THE PROGRAM WORK?

POSSIBLE OUTCOME CRITERIA FOR A PARENT TRAINING PROGRAM

1.	ENROLLMENT:	Who enrolls (or does not enroll) in the program?
2.	COMPLETION:	Who completes (or drops out from) the program?
3.	PARTICIPATION:	Who participates more (or less), carrying out demands of the program?
4.	CONSUMER SATISFACTION:	Who expresses high (or lower) satisfaction with the program?
5.	PROFICIENCY:	Who learns (or does not learn) what the program aims to teach?
6.	GENERALIZATION:	Who carries out (or does not carry out) programs at home, putting what they have learned into practice?
7.	MAINTAINENCE:	Who follows through (or does not follow through) months and even years later?
8.	ATTITUDES & ADJUSTMENT:	Who experiences positive (or negative) changes in attitudes, confidence, family relationships, coping etc.
9.	ADVOCACY:	Who is more (or less) able after training to relate to the service delivery system in a more effective way?
10.	PLACEMENT:	Who is less (or more) likely after training to place the child out of the home?

WHO DID THE PROGRAM WORK FOR?

PREDICTION OF PARENT TRAINING PROGRAM OUTCOME

DEMOGRAPHIC VARIABLES

SOCIOECONOMIC STATUS (Education and occupation)
FAMILY INCOME
MARITAL STATUS (Single or married)
EDUCATION of primary parent
AGE of primary parent
EMPLOYMENT of primary parent
MILEAGE traveled to the meeting place

PARENTS' EXPECTATIONS

SUCCESS in the program
PROBLEMS in teaching
COMMITMENT to teaching
RESPONSIBILITY for teaching

PRIOR RELATED EXPERIENCE/SKILLS

BEHAVIOR MODIFICATION KNOWLEDGE
BEHAVIOR MODIFICATION EXPERIENCE
PARENT GROUP MEMBERSHIP
TEACHING OF CHILD AT HOME

CHILD CHARACTERISTICS

AGE
SELF-HELP SKILLS
SELF-HELP QUOTIENT (Self-help skills/age)
BEHAVIOR PROBLEMS

FAMILY CHARACTERISTICS

MARITAL ADJUSTMENT
FAMILY ENVIRONMENT
FAMILY COPING STYLES